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https://dmas.virginia.gov
MEDICAID MEMO

Last Updated: 03/09/2022

Billing Information Correction for Submitting Paper UB-92 Medicare Part A and B Claims

The purpose of this memorandum is to provide you with specific information regarding the submission of Medicare "Crossover Claims" to the Department of Medical Assistance Services (DMAS). The issues addressed in this memorandum are a restatement of billing requirements that were communicated in the Medicaid Memo dated October 28, 2003, titled Changes in Billing for Medicare "Crossover" Claims. Other issues addressed in this memorandum are based on questions from providers and billing problems that have been observed. We are providing some additional information to help clarify these issues including detailed billing instructions for UB-92 Medicare Part A and B claims.

n. **For nursing home services**, the appropriate paper invoice to use when billing DMAS is determined by which form is used to bill the service to Medicare. This is a correction to the Medicaid Memo dated October 28, 2003. If Medicare is billed using the UB-92, then the paper crossover claim should be billed to DMAS on the UB-92. Skilled nursing homes should use **Bill Type 211** for Part A Medicare Deductible and Coinsurance claims and **Bill Type 221** for Part B Medicare Deductible and Coinsurance claims. Non-skilled nursing homes use **Bill Type 611** for Part A Medicare Deductible and Coinsurance claims and **Bill Type 621** for Part B Medicare Deductible and Coinsurance claims. If the CMS-1500 form is used to bill Medicare for Part B then the Medicaid Title XVIII Deductible and Coinsurance Invoice must be used to bill for Part B claims. However, DMAS does not expect nursing homes to use the Title XVIII (Medicare) Invoice to bill Medicare Part B claims with the exception of Durable Medical Equipment Regional Carrier (DMERC) supplies that were billed to the Medicare Intermediary.

- Enter the word **"CROSSOVER"** in block 11 of all UB-92 paper claim

submissions for originals, adjustments, and voids. This is the only way our automated claims processing system can identify the claim as a Medicare crossover claim. Without the word "**CROSSOVER**" entered in block 11, the claim will process as a regular Medicaid claim and not calculate the coinsurance and deductible amounts.

n. A 5-digit procedure code **should not** be entered in block 80 (Principal Procedure Code) of the UB-92 Medicare Part B paper claim submission. Block 80 **must be left blank** for UB-92 Medicare Part B paper claims. If applicable, an ICD-9-CM procedure code should be entered in Block 80 for Medicare Part A claims.

n. Coordination of Benefit (COB) codes (83 and 85) must accurately be printed in blocks 39-41 of the UB-92 claim form. The first occurrence of COB code 83 indicates that Medicare paid and there should always be a dollar value associated with this COB code. The code A1 indicates the Medicare deductible and code A2 indicates the Medicare co-insurance. COB code 85 is to be used when another insurance is billed and there is not a payment from that carrier. For the deductibles and co-insurance due from any other carrier(s) (not Medicare) the code for reporting the amount paid is B1 for the deductibles and B2 for the co-insurance. The national standard for billing value codes is to complete blocks 39a - 41a before proceeding to block 39b. This is also a correction to the October 28, 2003, Medicaid Memo.

n. Medicare Part A and B claims for individuals with third party coverage have resulted in incorrect denials for edit 0313 "Bill Any Other Available Insurance". The denials were a result of the incorrect system manipulation of COB 85 (Billed and Not Paid). Claims incorrectly denied for this reason will be reprocessed. However, it is important to note that original crossover claims from the Medicare Intermediary are correctly denied for edit 0313 when the Medicaid recipient has insurance coverage in addition to Medicare and Medicaid. The intent is for the provider to exhaust all insurance coverage before billing Medicaid, which is the payer of last resort.

n. Block 77 on the UB-92 is **not** required. The instructions in the October 28,

2003, memo erroneously indicated that this field is required.

Resubmission of Claims

Due to system issues, claims submitted prior to February 20, 2004, without a procedure code were suspended and a turnaround document (TAD) was sent to providers. However, the returned TAD did not result in payment. For these claims, you will need to resubmit a new invoice for payment.

ELIGIBILITY AND CLAIMS STATUS INFORMATION

The Automated Response System (ARS) provides twenty-four-hour-a-day, seven-day-a-week Internet access to eligibility information, service limits, claim status, prior authorizations,

provider check status and prescribing provider ID lookup (for pharmacy providers). The ARS system can be used by anyone with an internet-connected PC, web browser and an active Medicaid provider number. Unlike MediCall (the voice response system), there are no limits to the number of inquires per session. Finally, this system is HIPAA compliant. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 800-884-9730 or 800-772-9996. Both options are available at no cost to the provider.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its provider manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov (***please note the new DMAS website address***). Refer to the Provider Column to find Medicaid and SLH provider manuals or click on “Medicaid Memos to Providers” to view Medicaid

Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet, or would like a paper copy of a manual, you can order these by contacting Commonwealth-Martin at 804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates requested.

"HELPLINE"

The "HELPLINE" is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays, to answer questions. The "HELPLINE" numbers are:

786-6273
Richmond area
1-800-552-8627
All other areas

Please remember that the "HELPLINE" is for provider use only.